"medical food" means a food that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation and is formulated to be consumed or administered enterally under the direction of a Practitioner.

Specialized Infant Formulas
Horizon BCBSNJ covers specialized non-standard infant formulas to the same extent and subject to the same terms and conditions as coverage is provided under this Policy for Prescription Drugs. Horizon BCBSNJ covers specialized non-standard infant formulas provided:

a) The Child's Practitioner has diagnosed the Child as having multiple food protein intolerance and has determined the formula to be medically necessary; and
b) The Child has not been responsive to trials of standard non-cow milk-based formulas, including soybean and goat milk.

Horizon BCBSNJ may review continued Medical Necessity and Appropriateness of the specialized infant formula.

X-Rays and Laboratory Tests
Horizon BCBSNJ covers x-rays and laboratory tests which are Medically Necessary and Appropriate to treat an Illness or Injury. But, except as covered under this Policy's Preventive Care section, Horizon BCBSNJ does not pay for x-rays and tests done as part of routine physical checkups.

Prescription Drugs
Subject to Horizon BCBSNJ Pre-Approval, for certain Prescription Drugs Horizon BCBSNJ covers drugs to treat an Illness or Injury and contraceptive drugs which require a Practitioner's prescription. But Horizon BCBSNJ only covers drugs which are:

a) approved for treatment of the Covered Person's Illness or Injury by the Food and Drug Administration;
b) approved by the Food and Drug Administration for the treatment of a particular diagnosis or condition other than the Covered Person's and recognized as appropriate medical treatment for the Covered Person's diagnosis or condition in one or more of the following established reference compendia:
    1. The American Hospital Formulary Service Drug Information;
    2. The United States Pharmacopeia Drug Information; or
c) recommended by a clinical study or recommended by a review article in a major peer-reviewed professional journal.

Coverage for the above drugs also includes medically necessary services associated with the administration of the drugs.

In no event will Horizon BCBSNJ pay for:

a) drugs labeled: "Caution - Limited by Federal Law to Investigational Use"; or
b) any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed, except as stated above.

And Horizon BCBSNJ excludes drugs that can be bought without a prescription, even if a Practitioner orders them.

Horizon BCBSNJ has identified certain Prescription Drugs for which Pre-Approval is required. Horizon BCBSNJ will provide the list of Prescription Drugs for which Pre-Approval is required to each Employee prior to enforcing the Pre-Approval requirement. Horizon BCBSNJ will give at least 30 days advance written notice to the Employee before adding a Prescription Drug to the list.

If a Covered Person brings a prescription for a Prescription Drug for which Horizon BCBSNJ requires Pre-Approval to a Pharmacy and Pre-Approval has not yet been secured, the Pharmacy will contact

the Practitioner to request that the Practitioner contact Horizon BCBSNJ to secure Pre-Approval. The Pharmacy will dispense a 96-hour supply of the Prescription Drug. Horizon BCBSNJ will review the Pre-Approval request within the time period allowed by law. If Horizon BCBSNJ gives Pre-Approval, Horizon BCBSNJ will notify the Pharmacy and the balance of the Prescription Drug will be dispensed with benefits for the Prescription Drug being paid subject to the terms of this Policy. If Horizon BCBSNJ does not give Pre-Approval, the Covered Person may ask that the Pharmacy dispense the balance of the Prescription Drug, with the Covered Person paying for the Prescription Drug. The Covered Person may submit a claim for the Prescription Drug, subject to the terms of this Policy.

Supplies to Administer Prescription Drugs
Horizon BCBSNJ covers Medically Necessary and Appropriate supplies which require a prescription, are prescribed by a Practitioner, and are essential to the administration of the Prescription Drug.

COVERED CHARGES WITH SPECIAL LIMITATIONS

Cancer Clinical Trial
Horizon BCBSNJ covers practitioner fees, laboratory expenses and expenses associated with Hospitalization, administering of treatment and evaluation of the Covered Person during the course of treatment or a condition associated with a complication of the underlying disease or treatment, which are consistent with usual and customary patterns and standards of care incurred whenever a Covered Person receives medical care associated with an Approved Cancer Clinical Trial. Horizon BCBSNJ will cover charges for such items and services only if they would be covered for care and treatment in a situation other than an Approved Cancer Clinical Trial.

Horizon BCBSNJ does not cover the cost of investigational drugs or devices themselves, the cost of any non-health services that might be required for a Covered Person to receive the treatment or intervention, or the costs of managing the research, or any costs which would not be covered under this Policy for treatments that are not Experimental or Investigational.

Dental Care and Treatment
Horizon BCBSNJ covers:
a) the diagnosis and treatment of oral tumors and cysts; and
b) the surgical removal of bony impacted teeth.

Horizon BCBSNJ also covers treatment of an Injury to natural teeth or the jaw, but only if:
a) the Injury was not caused, directly or indirectly by biting or chewing; and
b) all treatment is finished within 6 months of the date of the Injury.
Treatment includes replacing natural teeth lost due to such Injury. But in no event does Horizon BCBSNJ cover orthodontic treatment.

For a Covered Person who is severely disabled or who is a Child under age 6, Horizon BCBSNJ covers:
a) general anesthesia and Hospitalization for dental services; and
b) dental services rendered by a dentist regardless of where the dental services are provided for a medical condition covered by this Policy which requires Hospitalization or general anesthesia.

Treatment for Temporomandibular Joint Disorder (TMJ)
Horizon BCBSNJ covers charges for the Medically Necessary and Appropriate surgical and non-surgical treatment of TMJ in a Covered Person. However, Horizon BCBSNJ does not cover any charges for orthodontia, crowns or bridgework.

Mammogram Charges
Horizon BCBSNJ covers charges made for mammograms provided to a female Covered Person according to the schedule given below. Benefits will be paid, subject to all the terms of this Policy, and the following limitations:
Horizon BCBSNJ will cover charges for:
a) one baseline mammogram for a female Covered Person, age 35 - 39
b) one mammogram, every year, for a female Covered Person age 40 and older.

Please note that mammograms are included under the Preventive Care provision. A female Covered Person may elect to apply any unused Preventive Care allowance for a mammogram. If a Covered Person has exhausted the available annual Preventive Care benefit, the mammogram may be covered subject to the terms of this Mammogram Charges provision.

Colorectal Cancer Screening Charges
Horizon BCBSNJ covers charges made for colorectal cancer screening provided to a Covered Person age 50 or over and to younger Covered Persons who are considered to be high risk for colorectal cancer. Benefits will be paid, subject to all the terms of this Policy, and the following limitations:

Subject to the American Cancer Society guidelines, and medical necessity as determined by the Covered Person's Practitioner in consultation with the Covered Person regarding methods to use, Horizon BCBSNJ will cover charges for:
a) Annual gFOBT (guaiac-based fecal occult blood test) with high test sensitivity for cancer;
b) Annual FIT (immunochemical-based fecal occult blood test) with high test sensitivity for cancer;
c) Stool DNA (sDNA) test with high sensitivity for cancer
d) flexible sigmoidoscopy,
e) colonoscopy;
f) contrast barium enema;
g) Computed Tomography (CT) Colonography
h) any combination of the services listed in items a – g above; or
i) any updated colorectal screening examinations and laboratory tests recommended in the American Cancer Society guidelines.

Horizon BCBSNJ will cover the above methods at the frequency recommended by the most recent published guidelines of the American Cancer Society and as determined to be medically necessary by the Covered Person's practitioner in consultation with the Covered Person.

High risk for colorectal cancer means a Covered Person has:

a) A family history of: familial adenomatous polyposis, heriditary non-polyposis colon cancer; or breast, ovarian, endometrial or colon cancer or polyps;
b) Chronic inflammatory bowel disease; or
c) A background, ethnicity or lifestyle that the practitioner believes puts the person at elevated risk for colorectal cancer.

Please note that since colorectal cancer screening is included under the Preventive Care provision, a Covered Person may elect to apply any unused Preventive Care allowance for colorectal cancer screening. If a Covered Person has exhausted the available annual Preventive Care benefit, or elects not to use any available Preventive Care benefit to cover the colorectal cancer screening, the colorectal cancer screening may be covered subject to the terms of this Colorectal Cancer Screening Charges provision.

The following "Pre-Existing Conditions Limitation" and "Continuity of Coverage" provisions only apply to Policies issued to Policyholders of at least two but not more than five eligible Employees. These provisions also apply to "Late Enrollees" under the Policies issued to any Small Employer. However, this provision does not apply to Late Enrollees if 10 or more Late Enrollees request enrollment during any 30 day enrollment period provided for in this Policy. See this Policy's EMPLOYEE COVERAGE and DEPENDENT COVERAGE sectionssto determine if a Covered Person is a Late Enrollee.

The "Pre-Existing Conditions Limitation" provision does not apply to a Dependent who is under age 19 or who is an adopted child or who is a child placed for adoption or to a newborn child if the Employee enrolls the Dependent and agrees to make the required payments within 31 days after the Dependent's Eligibility Date.

Pre-Existing Conditions Limitation
A Pre-Existing Condition is an Illness or Injury which manifests itself in the six months before a Covered Person's Enrollment Date, and for which medical advice, diagnosis, care, or treatment was recommended or received during the six months immediately preceding the Enrollment Date.

Horizon BCBSNJ does not pay benefits for charges for Pre-Existing Conditions for Covered Persons age 19 or older for 180 days measured from the Enrollment Date. This 180 day period may be reduced by the length of time the Covered Person was covered under any Creditable Coverage if, without application of any Waiting Period, the Creditable Coverage was continuous to a date not more than 90 days prior to becoming a Covered Person. Refer to the Continuity of Coverage section below.

This limitation does not affect benefits for other unrelated conditions, or pregnancy, or birth defects in a covered Dependent child. Genetic information will not be treated as a Pre-Existing Condition in the absence of a diagnosis of the condition related to that information. And Horizon BCBSNJ waives this limitation for a Covered Person's Pre-Existing Condition if the condition was payable under Creditable Coverage which insured the Covered Person right before the Covered Person's coverage under this Policy started. The next section shows other exceptions.

Continuity of Coverage
If a new Covered Person was covered under Creditable Coverage prior to enrollment under this Policy and the Creditable Coverage was continuous to a date not more than 90 days prior to the Enrollment Date under this Policy, Horizon BCBSNJ will provide credit as follows. Standard method Horizon BCBSNJ gives credit for the time the Covered Person was covered under the Creditable Coverage without regard to the specific benefits included in the Creditable Coverage. Horizon BCBSNJ counts the days the Covered Person was covered under Creditable Coverage, except that days that occur before any lapse in coverage of more than 90 days are not counted. Horizon BCBSNJ applies these days to reduce the duration of the Pre-Existing Condition limitation under this Policy. The person must sign and complete his or her enrollment form within 30 days of the date the Employee's active Full-Time service begins. Horizon BCBSNJ does not cover any charges actually incurred before the person's coverage under this Policy starts. If the Policyholder has included an eligibility waiting period in this Policy, an Employee must still meet it, before becoming insured.

Private Duty Nursing Care
Horizon BCBSNJ **only** covers charges by a Nurse for Medically Necessary and Appropriate private duty nursing care if such care is authorized as part of a home health care plan, coordinated by a

Home Health Agency, and covered under the **Home Health Care Charges** section. Any other charges for private duty nursing care are a Non-Covered Charge.

Therapy Services
Therapy Services mean services or supplies, ordered by a Practitioner and used to treat, or promote recovery from, an Injury or Illness:

Subject to the stated limits, Horizon BCBSNJ covers the Therapy Services listed below when such services are provided to a Covered Person as an Outpatient Horizon BCBSNJ covers other types of Therapy Services provided they are performed by a licensed Provider, are Medically Necessary and Appropriate and are not Experimental or Investigational.

a. *Chelation Therapy* - the administration of drugs or chemicals to remove toxic concentrations of metals from the body.
b. *Chemotherapy* - the treatment of malignant disease by chemical or biological antineoplastic agents.
c. *Dialysis Treatment* - the treatment of an acute renal failure or a chronic irreversible renal insufficiency by removing waste products from the body. This includes hemodialysis and peritoneal dialysis.
d. *Radiation Therapy* - the treatment of disease by x-ray, radium, cobalt, or high energy particle sources. Radiation therapy includes rental or cost of radioactive materials. Diagnostic Services requiring the use of radioactive materials are not radiation therapy.
e. *Respiration Therapy* - the introduction of dry or moist gases into the lungs.

Horizon BCBSNJ covers the Therapy Services listed below, subject to stated limitations:

f. *Cognitive Rehabilitation Therapy* - the retraining of the brain to perform intellectual skills which it was able to perform prior to disease, trauma, Surgery, or previous therapeutic process; or the training of the brain to perform intellectual skills it should have been able to perform if there were not a congenital anomaly.

g. *Speech Therapy* except as stated below, treatment for the correction of a speech impairment resulting from Illness, Surgery, Injury, congenital anomaly, or previous therapeutic processes. Exception: For a Covered Person who has been diagnosed with a biologically-based mental illness, speech therapy means treatment of a speech impairment.

Coverage for Cognitive Rehabilitation Therapy and Speech Therapy, **combined,** is limited to 30 visits per Calendar Year.

h. *Occupational Therapy* - except as stated below, treatment to restore a physically disabled person's ability to perform the ordinary tasks of daily living. Exception: For a Covered Person who has been diagnosed with a biologically-based mental illness, occupational therapy means treatment to develop a Covered Person's ability to perform the ordinary tasks of daily living.

i. *Physical Therapy* - except as stated below, the treatment by physical means to relieve pain, restore maximum function, and prevent disability following disease, Injury or loss of limb. Exception: For a Covered Person who has been diagnosed with a biologically-based mental illness, physical therapy means treatment to develop a Covered Person's physical function.

Coverage for Occupational Therapy and Physical Therapy, **combined**, is limited to 30 visits per Calendar Year.

j. Infusion Therapy - subject to Horizon BCBSNJ Pre-Approval, the administration of antibiotic, nutrients, or other therapeutic agents by direct infusion. Horizon BCBSNJ will reduce benefits by 50% with respect to charges for Infusion Therapy which are not Pre-Approved by Horizon BCBSNJ provided that benefits would otherwise be payable under this Policy.

Note: The limitations on Therapy Services contained in this Therapy Services provision do not apply to any therapy services that are received under the Home Health Care provision, to services provided while a Covered Person is confined in a Facility or to therapy services received under the Diagnosis and Treatment of Autism or Other Developmental Disabilities provision.

Diagnosis and Treatment of Autism and Other Developmental Disabilities
Horizon BCBSNJ provides coverage for charges for the screening and diagnosis of autism and other developmental disabilities.

If a Covered Person's primary diagnosis is autism or another developmental disability Horizon BCBSNJ provides coverage for the following medically necessary therapies as prescribed through a treatment plan and subject to the benefit limits set forth below:

a) occupational therapy where occupational therapy refers to treatment to develop a Covered Person's ability to perform the ordinary tasks of daily living;
b) physical therapy where physical therapy refers to treatment to develop a Covered Person's physical function; and
c) speech therapy where speech therapy refers to treatment of a Covered Person's speech impairment.

Coverage for occupational therapy and physical therapy combined is limited to 30 visits per Calendar Year. Coverage for speech therapy is limited to 30 visits per Calendar Year. These therapy services are covered whether or not the therapies are restorative. The therapy services covered under this provision do not reduce the available therapy visits available under the Therapy Services provision.

If a Covered Person's primary diagnosis is autism, and the Covered Person is under 21 years of age, in addition to coverage for the therapy services as described above, Horizon BCBSNJ also cover medically necessary behavioral interventions based on the principles of applied behavior analysis and related structured behavioral programs as prescribed through a treatment plan.

The treatment plan(s) referred to above must be in writing, signed by the treating physician, and must include: a diagnosis, proposed treatment by type, frequency and duration; the anticipated outcomes stated as goals; and the frequency by which the treatment plan will be updated. Horizon BCBSNJ may request additional information if necessary to determine the coverage under the Policy. Horizon BCBSNJ may require the submission of an updated treatment plan once every six months unless Horizon BCBSNJ and the treating physician agree to more frequent updates

If a Covered Person:

a) is eligible for early intervention services through the New Jersey Early Intervention System; and
b) has been diagnosed with autism or other developmental disability; and
c) receives physical therapy, occupational therapy, speech therapy, applied behavior analysis or related structured behavior services

the portion of the family cost share attributable to such services is a Covered Charge under this Policy. The deductible, coinsurance or copayment as applicable to a non-specialist physician visit for treatment of an Illness or Injury will apply to the family cost share.

The therapy services a Covered Person receives through New Jersey Early Intervention do not reduce the therapy services otherwise available under this Diagnosis and Treatment of Autism and Other Disabilities provision.

Fertility Services
Subject to Horizon BCBSNJ Pre-Approval Horizon BCBSNJ covers charges for procedures and Prescription Drugs to enhance fertility, except where specifically excluded in this Policy. Horizon BCBSNJ covers charges for: artificial insemination; and standard dosages, lengths of treatment and cycles of therapy of Prescription Drugs. The Prescription Drugs noted in this section are subject to the terms and conditions of the Prescription Drugs section of this Policy.

Horizon BCBSNJ will reduce benefits by 50% with respect to charges for Fertility Services which are not Pre-Approved by Horizon BCBSNJ provided that benefits would otherwise be payable under this Policy.

Preventive Care
Horizon BCBSNJ covers charges for routine physical examinations including related laboratory tests and x-rays. Horizon BCBSNJ also covers charges for immunizations and vaccines, well baby care, pap smears, mammography, screening tests, bone density testing, colorectal cancer screening, and Nicotine Dependence Treatment. But Horizon BCBSNJ limits what Horizon BCBSNJ pays each Calendar Year to:

a) $750 per Covered Person for a Dependent child from birth until the end of the Calendar Year in which the Dependent child attains age one;

b) $500 per Covered Person for all other Covered Persons.

These charges are not subject to any Copayment, Cash Deductible or Coinsurance. The $750 and $500 limits do not apply to services from a Network Practitioner.

Immunizations and Lead Screening

Horizon BCBSNJ will cover charges for:
a) screening by blood measurement for lead poisoning for children, including confirmatory blood lead testing and medical evaluation as specified by the New Jersey Department of Health and Senior Services and any necessary medical follow-up and treatment for lead poisoned children; and
b) all childhood immunizations as recommended by the Advisory Committee on Immunization Practices of the United States Public Health Services and New Jersey Department of Health and Senior Services.

Hearing Aids
Horizon BCBSNJ covers charges for medically necessary services incurred in the purchase of a hearing aid for a Covered Person age 15 or younger. Coverage includes the purchase of one hearing aid for each hearing-impaired ear every 24 months subject to a maximum amount payable for each hearing aid of $1,000. Coverage for all other medically necessary services incurred in the purchase of a hearing aid is unlimited. Such medically necessary services include fittings, examinations, hearing tests, dispensing fees, modifications and repairs, ear molds and headbands for bone-anchored hearing implants. The hearing aid must be recommended or prescribed by a licensed physician or audiologist.

The Deductible, Coinsurance or Copayment as applicable to a non-specialist physician visit for treatment of an Illness or Injury will apply to a hearing aid and the medically necessary services incurred in the purchase of a hearing aid.

Newborn Hearing Screening
Horizon BCBSNJ covers charges up to a maximum of 28 days following the date of birth for screening for newborn hearing loss by appropriate electrophysiologic screening measures. In addition, Horizon BCBSNJ covers charges between age 29 days and 36 months for the periodic monitoring of infants for delayed onset hearing loss.

Vision Screening
Horizon BCBSNJ covers vision screening for Dependent children, through age 17, to determine the need for vision correction. The vision screening is generally performed by the pediatrician during the course of a routine physical examination. The vision screening may suggest that the Covered Person should undergo a vision examination. Such vision examination is not covered under this Policy.

Therapeutic Manipulation
Horizon BCBSNJ limits what Horizon BCBSNJ covers for therapeutic manipulation to 30 visits per Calendar Year. And Horizon BCBSNJ covers no more than two modalities per visit. Charges for such treatment above these limits are a Non-Covered Charge.

Transplant Benefits
Horizon BCBSNJ covers Medically Necessary and Appropriate services and supplies for the following types of transplants:

a) Cornea
b) Kidney
c) Lung
d) Liver
e) Heart
f) Pancreas
g) Intestine
h) Allogeneic Bone Marrow
i) Autologous Bone Marrow transplant and Associated Dose-Intensive Chemotherapy, but only if perfirmed by institutions approved by the National Cancer Institute, or pursuant to protocols consistent with the guidelines of the American Society of Clinical Oncologists;
j) Peripheral Blood Stem Cell transplants, but only if performed by institutions approved by the National Cancer Institute, or pursuant to protocols consistent with the guidelines of the American Society of Clinical Oncologists.

If the donor does not have health coverage that would cover the costs associated with his or her role as donor, this Policy will cover the donor's medical costs associated with the donation. Horizon BCBSNJ does not cover costs for travel, accommodations or comfort items.

IMPORTANT NOTICE

This Policy has utilization review features. Under these features, Horizon BCBSNJ, a health care review organization reviews Hospital admissions and Surgery performed outside of a Practitioner's office for Carrier. These features must be complied with if a Covered Person:

a) is admitted as an Inpatient to a Hospital, or

b) is advised to enter a Hospital or have Surgery performed outside of a Practitioner's office. If a Covered Person does not comply with these utilization review features, he or she will not be eligible for full benefits under this Policy. See the **Utilization Review Features** section for details.

This Policy has Specialty Case Management. Under this provision, a Case Coordinator reviews a Covered Person's medical needs in clinical situations with the potential for catastrophic claims to determine whether case management may be available and appropriate. See the **Specialty Case Management** section for details.

This Policy has centers of excellence features. Under these features, a Covered Person may obtain necessary care and treatment from Providers with whom Horizon BCBSNJ has entered into agreements. See the **Centers of Excellence Features** section for details.

What Horizon BCBSNJ pays is subject to all of the terms of this Policy. Read this Policy carefully and keep it available when consulting a Practitioner.

If an Employee has any questions after reading this Policy he or she should call The Group Claim Office at the number shown on his or her identification card.

This Policy is not responsible for medical or other results arising directly or indirectly from the Covered Person's participation in these Utilization Review, Specialty Case Management or Centers of Excellence Features.

UTILIZATION REVIEW FEATURES

Important Notice: If a Covered Person does not comply with this Policy's utilization review features, he or she will not be eligible for full benefits under this Policy.

Compliance with this Policy's utilization review features does not guarantee what Horizon BCBSNJ will pay for Covered Charges. What Horizon BCBSNJ pays is based on:

a) the Covered Charges actually incurred;

b) the Covered Person being eligible for coverage under this Policy at the time the Covered Charges are incurred; and

c) the Cash Deductible, Copayment and Coinsurance provisions, and all of the other terms of this Policy.

Definitions

"Hospital admission" means admission of a Covered Person to a Hospital as an Inpatient for Medically Necessary and Appropriate care and treatment of an Illness or Injury.

By "covered professional charges for Surgery" Horizon BCBSNJ means Covered Charges that are made by a Practitioner for performing Surgery. Any surgical charge which is not a Covered Charge under the terms of this Policy is not payable under this Policy.

"Regular working day" means Monday through Friday from 9 am. to 5 pm. Eastern Time, not including legal holidays.

Grievance Procedure
Please refer to **Appeals Procedure** Section

REQUIRED HOSPITAL STAY REVIEW

Important Notice: If a Covered Person does not comply with these Hospital stay review features, he or she will not be eligible for full benefits under this Policy.

Notice of Hospital Admission Required
Horizon BCBSNJ requires notice of all Hospital admissions. The times and manner in which the notice must be given is described below. When a Covered Person does not comply with the requirements of this section Horizon BCBSNJ reduces what it pays for covered Hospital charges as a penalty.

Pre-Hospital Review
All non-Emergency Hospital admissions must be reviewed by Horizon BCBSNJ before they occur. The Covered Person or the Covered Person's Practitioner must notify Horizon BCBSNJ and request a pre-hospital review. Horizon BCBSNJ must receive the notice and request as soon as possible before the admission is scheduled to occur. For a maternity admission, a Covered Person or his or her Practitioner must notify Horizon BCBSNJ and request a pre-hospital review at least 60 days before the expected date of delivery, or as soon as reasonably possible.

When Horizon BCBSNJ receives the notice and request, We evaluate:
a) the Medical Necessity and Appropriateness of the Hospital admission
b) the anticipated length of stay and
c) the appropriateness of health care alternatives, like home health care or other out-patient care.

Horizon BCBSNJ notifies the Covered Person's Practitioner by phone, of the outcome of our review. And we confirm the outcome of our review in writing.

If Horizon BCBSNJ authorizes a Hospital admission, the authorization is valid for:
a) the specified Hospital;
b) the named attending Practitioner; and
c) the authorized length of stay.

The authorization becomes invalid and the Covered Person's admission must be reviewed by Horizon BCBSNJ again if:
a) he or she enters a Facility other than the specified Facility
b) he or she changes attending Practitioners; or
c) more than 60 days elapse between the time he or she obtains authorization and the time he or she enters the Hospital, except in the case of a maternity admission.

Emergency Admission
Horizon BCBSNJ must be notified of all Emergency admissions by phone. This must be done by the Covered Person or the Covered Person's Practitioner no later than the end of the next regular working day or as soon as possible after the admission occurs.

When Horizon BCBSNJ is notified by phone, they require the following information:
a) the Covered Person's name, social security number and date of birth;
b) the Covered Person group plan number;
c) the reason for the admission
d) the name and location of the Hospital
e) when the admission occurred; and
f) the name of the Covered Person's Practitioner.

Continued Stay Review
The Covered Person or his or her Practitioner, must request a continued stay review for any Emergency admission. This must be done at the time Horizon BCBSNJ is notified of such admission.

The Covered Person, or his or her Practitioner, must also initiate a continued stay review whenever it is Medically Necessary and Appropriate to change the authorized length of a Hospital stay. This must be done before the end of the previously authorized length of stay.

Horizon BCBSNJ also has the right to initiate a continued stay review of any Hospital admission. And Horizon BCBSNJ may contact the Covered Person's Practitioner or Hospital by phone or in writing.

In the case of an Emergency admission, the continued stay review evaluates:
a) the Medical Necessity and Appropriateness of the Hospital admission;
b) the anticipated length of stay; and
c) the appropriateness of health care alternatives.

In all other cases, the continued stay review evaluates:
a) the Medical Necessity and Appropriateness of extending the authorized length of stay; and the
b) appropriateness of health care alternatives.

Horizon BCBSNJ notifies the Covered Person's Practitioner by phone, of the outcome of the review. And Horizon BCBSNJ confirms the outcome of the review in writing. The notice always includes any newly authorized length of stay.

Penalties for Non-Compliance
In the case of a non-Emergency Hospital admission, as a penalty for non-compliance. Horizon BCBSNJ reduces what it pays for covered Hospital charges, **by 50%** if**:**
a) the Covered Person does not request a pre-hospital review; or
b) the Covered Person does not request a pre-hospital review as soon as reasonably possible before the Hospital admission is scheduled to occur; or
c) Horizon BCBSNJ authorization becomes invalid and the Covered Person does not obtain a new one; or
d) Horizon BCBSNJ does not authorize the Hospital admission.

In the case of an Emergency admission, as a penalty for non-compliance, Horizon BCBSNJ reduces what it pays for covered Hospital charges by 50%, if:
Horizon BCBSNJ is not notified of the admission at the times and in the manner described above;
a) Horizon BCBSNJ is not notified of the admission at the times and in the manner described above;
b) the Covered Person does not request a continued stay review; or
c) the Covered Person does not receive authorization for such continued stay.

The penalty applies to covered Hospital charges incurred after the applicable time limit allowed for giving notice ends.

For any Hospital admission, if a Covered Person stays in the Hospital longer than Horizon BCBSNJ authorizes, Horizon BCBSNJ reduces what it pays for covered Hospital charges incurred after the authorized length of stay ends by 50% as a penalty for non-compliance.

Penalties cannot be used to meet this Policy's Maximum Out of Pocket or Cash Deductible.

REQUIRED PRE-SURGICAL REVIEW

Important Notice: If a Covered Person does not comply with these pre-surgical review features, he or she will not be eligible for full benefits under this Policy.

Horizon BCBSNJ requires a Covered Person to get a pre-surgical review for any non-Emergency procedure performed outside of a Practitioner's office. When a Covered Person does not comply with the requirements of this section Horizon BCBSNJ reduces what it pays for covered professional charges for Surgery, as a penalty.

The Covered Person or his or her Practitioner, must request a pre-surgical review from Horizon BCBSNJ. Horizon BCBSNJ must receive the request at least 24 hours before the Surgery is scheduled to occur. If the Surgery is being done in a Hospital, on an Inpatient basis, the pre-surgical review request should be made at the same time as the request for a pre-hospital review.

When Horizon BCBSNJ receives the request, they evaluate the Medical Necessity and Appropriateness of the Surgery and they either:
a) approve the proposed Surgery, or
b) require a second surgical opinion regarding the need for the Surgery.

Horizon BCBSNJ notifies the Covered Person's Practitioner, by phone, of the outcome of the review. Horizon BCBSNJ also confirms the outcome of the review in writing.

Second Surgical Opinion
If Horizon BCBSNJ's review does not confirm the Medical Necessity and Appropriateness of the Surgery, the Covered Person may obtain a second surgical opinion. If the second opinion does not confirm the medical necessity of the Surgery, the Covered Person may obtain a third opinion, although he or she is not required to do so.

Horizon BCBSNJ will give the Covered Person a list of Practitioners in his or her area who will give a second opinion. The Covered Person may get the second opinion from a Practitioner of his or her own choosing, if the Practitioner:

a) is board certified and qualified, by reason of his or her specialty, to give an opinion on the proposed Surgery;
b) is not a business associate of the Covered Person's Practitioner; and
c) does not perform the Surgery if it is needed.

Horizon BCBSNJ gives second opinion forms to the Covered Person. The Practitioner he or she chooses fills them out, and then returns them to Horizon BCBSNJ.

Horizon BCBSNJ covers charges for additional surgical opinions, including charges for related x-ray and tests. But what Horizon BCBSNJ pays is based on all the terms of this Policy, except, these charges are not subject to the Cash Deductible or Coinsurance.

Pre-Hospital Review
If the proposed Surgery is to be done on an Inpatient basis, the Required Pre-Hospital Review section must be complied with. See the **Required Pre-Hospital Review** section for details.

Penalties for Non-Compliance
As a penalty for non-compliance, Horizon BCBSNJ reduces what it pays for covered professional charges for Surgery by 50% if:

a) the Covered Person does not request a pre-surgical review; or
b) Horizon BCBSNJ is not given at least 24 hours to review and evaluate the proposed Surgery; or
c) Horizon BCBSNJ requires additional surgical opinions and the Covered Person does not get those opinions before the Surgery is done;
d) Horizon BCBSNJ does not confirm the need for Surgery.

Penalties cannot be used to meet this Policy's Maximum Out of Pocket or Cash Deductible.

SPECIALTY CASE MANAGEMENT

Important Notice: No Covered Person is required, in any way, to accept a Specialty Case Management Plan recommended by Horizon BCBSNJ.

Definitions
"Specialty Case Management" means those services and supplies which meet both of the following tests:
a) They are determined, in advance, by Horizon BCBSNJ to be Medically Necessary and Appropriate and cost effective in meeting the long term or intensive care needs of a Covered Person in connection with a Catastrophic Illness or Injury.
b) While there are other covered services and supplies available under this Policy for the Covered Person's condition, the services and supplies the Horizon BCBSNJ offers to make available under the terms of this provision would not otherwise be payable under this Policy.

Please note: Horizon BCBSNJ has sole Discretion to determine whether to consider Specialty Case Management for a Covered Person.

"Catastrophic Illness or Injury" means one of the following:

a) head injury requiring an Inpatient stay
b) spinal cord Injury
c) severe burns over 20% or more of the body
d) multiple injuries due to an accident
e) premature birth
f) CVA or stroke
g) congenital defect which severely impairs a bodily function
h) brain damage due to either an accident or cardiac arrest or resulting from a surgical procedure
i) terminal Illness, with a prognosis of death within 6 months
j) Acquired Immune Deficiency Syndrome (AIDS)
k) Substance Abuse
l) Mental Illness
m) any other Illness or Injury determined by Horizon BCBSNJ to be catastrophic.

Specialty Case Management Plan
Horizon BCBSNJ will identify cases of Catastrophic Illness or Injury. The appropriateness of the level of patient care given to a Covered Person as well as the setting in which it is received will be evaluated. In order to maintain or enhance the quality of patient care for the Covered Person, Horizon BCBSNJ will develop a Specialty Case Management Plan.

A Specialty Case Management Plan is a specific written document, developed by Horizon BCBSNJ through discussion and agreement with:

a) the Covered Person, or his or her legal guardian, if necessary;
b) the Covered Person's attending Practitioner; and
c) Horizon BCBSNJ.

The Specialty Case Management Plan includes:

a) treatment plan objectives;
b) course of treatment to accomplish the stated objectives;

c) the responsibility of each of the following parties in implementing the plan: Horizon BCBSNJ ; attending Practitioner; Covered Person; Covered Person's family, if any; and
d) estimated cost and savings.

If Horizon BCBSNJ, the attending Practitioner, and the Covered Person agree in writing, on a Specialty Case Management Plan, the services and supplies required in connection with such Specialty Case Management Plan will be considered as Covered Charges under the terms of this Policy.

The agreed upon Specialty Case Management treatment must be ordered by the Covered Person's Practitioner.

Benefits payable under the Specialty Case Management Plan will be considered in the accumulation of any Calendar Year and Per Lifetime maximums.

Exclusion
Specialty Case Management does not include services and supplies that Horizon BCBSNJ determines to be Experimental or Investigational.

CENTERS OF EXCELLENCE FEATURES

Important Notice: No Covered Person is required, in any way, to receive medical care and treatment at a Center of Excellence.

Definitions
"Center of Excellence" means a Provider that has entered into an agreement with Horizon BCBSNJ to provide health benefit services for specific procedures. The Centers of Excellence are identified in the Listing of Centers of Excellence.

"Pre-Treatment Screening Evaluation" means the review of past and present medical records and current x-ray and laboratory results by the Center of Excellence to determine whether the Covered Person is an appropriate candidate for the Procedure.

"Procedure" means one or more surgical procedures or medical therapy performed in a Center of Excellence.

Covered Charges
In order for charges to be Covered Charges, the Center of Excellence must:
a) perform a Pre-Treatment Screening Evaluation; and
b) determine that the Procedure is Medically Necessary and Appropriate for the treatment of the Covered Person.

Benefits for services and supplies at a Center of Excellence will be subject to the terms and conditions of this Policy. However, the Utilization Review Features will not apply.

EXCLUSIONS

Payment will not be made for any charges incurred for or in connection with:

Care or treatment by means of ***acupuncture*** except when used as a substitute for other forms of anesthesia.

The amount of any charge which is greater than an ***Allowed Charge***.

Services for ***ambulance*** for transportation from a Hospital or other health care Facility, unless the Covered Person is being transferred to another Inpatient health care Facility.

Blood or blood plasma which is replaced by or for a Covered Person.

Care and or treatment by a ***Christian Science*** Practitioner.

Completion of claim forms.

Services or supplies related to ***Cosmetic Surgery*** except as otherwise stated in this Policy; complications of Cosmetic Surgery; drugs prescribed for cosmetic purposes.

Services related to ***custodial*** or ***domiciliary*** care.

Dental care or treatment, including appliances and dental implants, except as otherwise stated in this Policy.

Care or treatment by means of ***dose intensive chemotherapy***, except as otherwise stated in this Policy.

Services or supplies, the primary purpose of which is ***educational*** providing the Covered Person with any of the following: training in the activities of daily living; instruction in scholastic skills such as reading and writing; preparation for an occupation; or treatment for learning disabilities, except as otherwise stated in this Policy.

Experimental or Investigational treatments, procedures, hospitalizations, drugs, biological products or medical devices, except as otherwise stated in this Policy.

Extraction of teeth, except for bony impacted teeth.

Services or supplies for or in connection with:

a) except as otherwise stated in this Policy, exams to determine the need for (or changes of) ***eyeglasses*** or lenses of any type;
b) eyeglasses or lenses of any type except initial replacements for loss of the natural lens; or
c) eye surgery such as radial keratotomy or lasik surgery, when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmatism (blurring).

Services or supplies provided by one of the following members of the Employee's ***family***: spouse, child, parent, in- law, brother, sister or grandparent.

Services or supplies furnished in connection with any procedures to enhance ***fertility*** which involve harvesting, storage and/or manipulation of eggs and sperm. This includes, but is not limited to the following: a) procedures: invitro fertilization; embryo transfer; embryo freezing; and Gamete Intra-fallopian Transfer (GIFT) and Zygote Intra-fallopian Transfer (ZIFT); donor sperm, surrogate motherhood and b) Prescription Drugs not eligible under the Prescription Drugs section of the Policy.

Except as stated in the Hearing Aids and Newborn Hearing Screening provisions, Services or supplies related to ***hearing aids and hearing exams*** to determine the need for hearing aids or the need to adjust them.

Services or supplies related to ***herbal medicine***.

Services or supplies related to ***hypnotism***.

Services or supplies necessary because the Covered Person engaged, or tried to engage, in an ***illegal occupation*** or committed or tried to commit an indictable offense in the jurisdiction in which it is committed, or a felony. ***Exception:*** As required by 29 CFR 2590.702(b)(2)(iii) this exclusion does not apply to injuries that result from an act of domestic violence or to injuries that result from a medical condition.

Except as stated below, ***Illness or Injury***, including a condition which is the result of disease or bodily infirmity, which occurred on the job and which is covered or could have been covered for benefits provided under workers' compensation, employer's liability, occupational disease or similar law.
Exception: This exclusion does not apply to the following persons for whom coverage under workers' compensation is optional unless such persons are actually covered for workers' compensation: a self-employed person or a partner of a limited liability partnership, members of a limited liability company or partners of a partnership who actively perform services on behalf of the self-employed business, the limited liability partnership, limited liability company or the partnership.

Local anesthesia charges billed separately if such charges are included in the fee for the Surgery.

Membership costs for health clubs, weight loss clinics and similar programs.

Services and supplies related ***to marriage, career or financial counseling, sex therapy or family therapy, nutritional counseling and related services,*** except as otherwise stated in this Policy.

Nicotine Dependence Treatment, except as otherwise stated in the Preventive Care section of this Policy.

Any charge identified as a ***Non-Covered Charge*** or which are specifically limited or excluded elsewhere in this Policy, or which are not Medically Necessary and Appropriate, except as otherwise stated in this Policy.

Non-prescription drugs or supplies, except

a) insulin needles and syringes and glucose test strips and lancets;
b) colostomy bags, belts and irrigators; and
c) as stated in this Policy for food and food products for inherited metabolic diseases.

Services provided by a ***pastoral counselor*** in the course of his or her normal duties as a religious person.

Personal convenience or comfort items including, but not limited to, such items as TV's, telephones, first aid kits, exercise equipment, air conditioners, humidifiers, saunas, hot tubs.

Services or supplies that are not furnished by an eligible ***Provider.***

Services related to ***Private Duty Nursing care****,* except as provided under the Home Health Care section of this Policy.

Services or supplies related to ***rest or convalescent cures***.

Room and board charges for a Covered Person in any Facility for any period of time during which he or she was not physically present overnight in the Facility.

Except as stated in the Preventive Care section, ***Routine examinations*** or preventive care, including related x-rays and laboratory tests, except where a specific Illness or Injury is revealed or where a definite symptomatic condition is present; premarital or similar examinations or tests not required to diagnose or treat Illness or Injury.

Services or supplies related to ***Routine Foot Care*** except:

a) an open cutting operation to treat weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions;
b) the removal of nail roots; and
c) treatment or removal of corns, calluses or toenails in conjunction with the treatment of metabolic or peripheral vascular disease.

Self-administered services such as: biofeedback, patient-controlled analgesia on an Outpatient basis, related diagnostic testing, self-care and self-help training.

Services provided by a ***social worker****,* except as otherwise stated in this Policy.

Services or supplies*:*
a) eligible for payment under either federal or state programs (except Medicaid and Medicare). This provision applies whether or not the Covered Person asserts his or her rights to obtain this coverage or payment for these services;
b) for which a charge is not usually made, such as a Practitioner treating a professional or business associate, or services at a public health fair;
c) for which a Covered Person would not have been charged if he or she did not have health care coverage;
d) provided by or in a government Hospital except as stated below, or unless the services are for treatment:
- of a non-service Emergency; or
- by a Veterans' Administration Hospital of a non-service related Illness or Injury;

Exception: This exclusion does not apply to military retirees, their Dependents and the Dependents of active duty military personnel who are covered under both this Policy and under military health coverage and who receive care in facilities of the Uniformed Services.
e) provided outside the United States unless the Covered Person is outside the United States for one of the following reasons:
- travel, provided the travel is for a reason other than securing health care diagnosis and/or treatment, and travel is for a period of 6 months or less;

- business assignment, provided the Covered Person is temporarily outside the United States for a period of 6 months or less; or

Subject to Horizon BCBSNJ Pre-Approval, eligibility for full-time student status, provided the Covered Person is either enrolled and attending an Accredited School in a foreign country; or is participating in an academic program in a foreign country, for which the institution of higher learning at which the student matriculates in the United States, grants academic credit. Charges in connection with full-time students in a foreign country for which eligibility as a full-time student has not been Pre-Approved by Horizon BCBSNJ are Non-Covered Charges.

Stand-by services required by a Provider.

Sterilization reversal - services and supplies rendered for reversal of sterilization.

Surgery, sex hormones, and related medical, psychological and psychiatric services to change a Covered Person's sex; services and supplies arising from complications of sex transformation.

Telephone consultations.

Transplants, except as otherwise listed in this Policy.

Transportation, travel.

Vision therapy.

Vitamins and dietary supplements.

Services or supplies received as a result of a ***war*** or an act of war, if the Illness or Injury occurs while the Covered Person is serving in the military, naval or air forces of any country, combination of countries or international organization and Illness or Injury suffered as a result of special hazards incident to such service if the Illness or Injury occurs while the Covered Person is serving in such forces and is outside the home area.

Weight reduction or control, unless there is a diagnosis of morbid obesity; special foods, food supplements, liquid diets, diet plans or any related products and except as provided in the Nutritional Counseling and Food and Food Products for Inherited Metabolic Diseases provisions.

Wigs, toupees, hair transplants, hair weaving or any drug if such drug is used in connection with baldness.

CONTINUATION RIGHTS

COORDINATION AMONG CONTINUATION RIGHTS SECTIONS

As used in this section, COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1986 as enacted, and later amended.

A Covered Person may be eligible to continue his or her group health benefits under this Policy's **COBRA CONTINUATION RIGHTS** (CCR) section and under other continuation sections of this Policy at the same time.

Continuation Under CCR and **NEW JERSEY GROUP CONTINUATION RIGHTS** (NJGCR): A Covered Person who is eligible to continue his or her group health benefits under CCR is not eligible to continue under NJGCR.

Continuation under CCR and NJGCR and **NEW JERSEY CONTINUATION RIGHTS FOR OVER-AGE DEPENDENTS** (NJCROD): A Dependent who has elected to continue his or her coverage under the group policy under which his or her parent is currently covered pursuant to NJCROD shall not be entitled to further continue coverage under CCR or NJGCR when continuation pursuant to NJCROD ends.

Continuation Under CCR and any other continuation section of this Policy:

If a Covered Person elects to continue his or her group health benefits under this Policy's CCR or NJGCR, as applicable, and any other continuation other than NJCROD, the continuations:
a) start at the same time;
b) run concurrently; and
c) end independently on their own terms.

While covered under more than one continuation section, the Covered Person:
a) will not be entitled to duplicate benefits; and
b) will not be subject to the premium requirements of more than one section at the same time.

AN IMPORTANT NOTICE ABOUT CONTINUATION RIGHTS

The following COBRA CONTINUATION RIGHTS section may not apply to the Employer's Policy. The Employee must contact his or her Employer to find out if:

a) the Employer is subject to the COBRA CONTINUATION RIGHTS section in which case;
b) the section applies to the Employee.

COBRA CONTINUATION RIGHTS (Generally applies to employer groups with 20 or more employees)

Important Notice

Under this section, "Qualified Continuee" means any person who, on the day before any event which would qualify him or her for continuation under this section, is covered for group health benefits under this Policy as:
a) an active, covered Employee;
b) the spouse of an active, covered Employee; or

c) the Dependent child (except for the child of the Employee's domestic partner or or civil union partner) of an active, covered Employee. Except as stated below, any person who becomes covered under this Policy during a continuation provided by this section is not a Qualified Continuee.

A domestic partner, a civil union partner, and the child of an Employee's domestic partner or civil union partner are never considered Qualified Continuees eligible to elect CCR. They may, however, be a Qualified Continuee eligible to elect under New Jersey Group Continuation Rights (NJGCR). Refer to the NJGCR section for more information.

Exception: A child who is born to the covered Employee, or who is placed for adoption with the covered Employee during the continuation provided by this section is a Qualified Continuee.

If An Employee's Group Health Benefits Ends

If an Employee's group health benefits end due to his or her termination of employment or reduction of work hours, he or she may elect to continue such benefits for up to 18 months, unless he or she was terminated due to gross misconduct.
A Qualified Continuee may elect to continue coverage under COBRA even if the Qualified Continuee:
a) is covered under another group plan on or before the date of the COBRA election; or
b) is entitled to Medicare on or before the date of the COBRA election.

The continuation:
a) may cover the Employee and any other Qualified Continuee; and
b) is subject to the **When Continuation Ends** section.

Extra Continuation for Disabled Qualified Continuees
If a Qualified Continuee is determined to be disabled under Title II or Title XVI of the United States Social Security Act on the date his or her group health benefits would otherwise end due to the Employee's termination of employment or reduction of work hours or during the first 60 days of continuation coverage, he or she and any Qualified Continuee who is not disabled may elect to extend his or her 18 month continuation period above for up to an extra 11 months.

To elect the extra 11 months of continuation, the Qualified Continuee must give the Employer written proof of Social Security's determination of his or her disability before the earlier of:
a) the end of the 18 month continuation period; and
b) 60 days after the date the Qualified Continuee is determined to be disabled.

If, during this extra 11 month continuation period, the Qualified Continuee is determined to be no longer disabled under the Social Security Act, he or she must notify the Employer within 30 days of such determination, and continuation will end, as explained in the **When Continuation Ends** section.

An additional 50% of the total premium charge also may be required from the Qualified Continuee by the Employer during this extra 11 month continuation period.

If An Employee Dies While Insured
If an Employee dies while insured, any Qualified Continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to the **When Continuation Ends** section.

If An Employee's Marriage Ends

If an Employee's marriage ends due to legal divorce or legal separation, any Qualified Continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to the **When Continuation Ends** section.

If A Dependent Loses Eligibility
If a Dependent child's group health benefits end due to his or her loss of dependent eligibility as defined in this Policy, other than the Employee's coverage ending, he or she may elect to continue such benefits. However, such Dependent child must be a Qualified Continuee. The continuation can last for up to 36 months, subject to **When Continuation Ends.**

Concurrent Continuations
If a Dependent elects to continue his or her group health benefits due to the Employee's termination of employment or reduction of work hours, the Dependent may elect to extend his or her 18 month continuation period to up to 36 months, if during the 18 month continuation period, either:
a) the Dependent becomes eligible for 36 months of group health benefits due to any of the reasons stated above; or
b) the Employee becomes entitled to Medicare.

The 36 month continuation period starts on the date the 18 month continuation period started, and the two continuation periods will be deemed to have run concurrently.

Special Medicare Rule
Except as stated below, the “special rule” applies to Dependents of an Employee when the Employee becomes entitled to Medicare prior to termination of employment or reduction in work hours. The continuation period for a Dependent upon the Employee’s subsequent termination of employment or reduction in work hours will be the longer of the following:
a) 18 months from the date of the Employee’s termination of employment or reduction in work hours; or
b) 36 months from the date of the Employee’s earlier entitlement to Medicare.

Exception: If the Employee becomes entitled to Medicare more than 18 months prior to termination of employment or reduction in work hours, this “special rule” will not apply.

The Qualified Continuee's Responsibilities
A person eligible for continuation under this section must notify the Employer, in writing, of:
a) the legal divorce or legal separation of the Employee from his or her spouse; or
b) the loss of dependent eligibility, as defined in this Policy, of an insured Dependent child.

Such notice must be given to the Employer within 60 days of either of these events.

The Employer's Responsibilities
The Employer must notify the Qualified Continuee, in writing, of:
a) his or her right to continue this Policy's group health benefits;
b) the monthly premium he or she must pay to continue such benefits; and
c) the times and manner in which such monthly payments must be made.

Such written notice must be given to the Qualified Continuee within 44 days of:
a) the date a Qualified Continuee's group health benefits would otherwise end due to the Employee's death or the Employee's termination of employment or reduction of work hours; or

b) the date a Qualified Continuee notifies the Employer, in writing, of the Employee's legal divorce or legal separation from his or her spouse, or the loss of dependent eligibility of an insured Dependent child.

The Employer's Liability
The Employer will be liable for the Qualified Continuee's continued group health benefits to the same extent as, and in place of, Horizon BCBSNJ, if:
a) the Employer fails to remit a Qualified Continuee's timely premium payment to Horizon BCBSNJ on time, thereby causing the Qualified Continuee's continued group health benefits to end; or
b) the Employer fails to notify the Qualified Continuee of his or her continuation rights, as described above.

Election of Continuation
To continue his or her group health benefits, the Qualified Continuee must give the Employer written notice that he or she elects to continue. An election by a minor Dependent Child can be made by the Dependent Child's parent or legal guardian. This must be done within 60 days of the date a Qualified Continuee receives notice of his or her continuation rights from the Employer as described above. And the Qualified Continuee must pay the first month's premium in a timely manner.

The subsequent premiums must be paid to the Employer, by the Qualified Continuee, in advance, at the times and in the manner specified by the Employer. No further notice of when premiums are due will be given.

The monthly premium will be the total rate which would have been charged for the group health benefits had the Qualified Continuee stayed insured under this Policy on a regular basis. It includes any amount that would have been paid by the Employer. Except as explained in the **Extra Continuation for Disabled Qualified Continuees** section, an additional charge of two percent of the total premium charge may also be required by the Employer.

If the Qualified Continuee fails to give the Employer notice of his or her intent to continue, or fails to pay any required premiums in a timely manner, he or she waives his or her continuation rights.

Grace in Payment of Premiums
A Qualified Continuee's premium payment is timely if, with respect to the first payment after the Qualified Continuee elects to continue, such payment is made no later than 45 days after such election. In all other cases, such premium payment is timely if it is made within 31 days of the specified date.

If timely payment is made to the plan in an amount that is not significantly less than the amount the Employer requires to be paid for the period of coverage, then the amount paid is deemed to satisfy the Employer's requirement for the amount that must be paid, unless the plan notifies the Qualified Continuee of the amount of the deficiency and grants an additional 30 days for payment of the deficiency to be made. An amount is not significantly less than the amount the Employer requires to be paid for a period of coverage if and only if the shortfall is no greater than the lesser of the following two amounts:
a) Fifty dollars (or such other amount as the Commissioner may provide in a revenue ruling, notice, or other guidance published in the Internal Revenue Code Bulletin); or
b) Ten percent of the amount the plan requires to be paid.

Payment is considered as made on the date on which it is sent to the Employer.

When Continuation Ends
A Qualified Continuee's continued group health benefits end on the first of the following:

a) with respect to continuation upon the Employee's termination of employment or reduction of work hours, the end of the 18 month period which starts on the date the group health benefits would otherwise end;
b) with respect to a Qualified Continuee who has elected an additional 11 months of continuation due to his or her own disability or the disability of a family member, the earlier of:

- the end of the 29 month period which starts on the date the group health benefits would otherwise end; or
- the first day of the month which coincides with or next follows the date which is 30 days after the date on which a final determination is made that a disabled Qualified Continuee is no longer disabled under Title II or Title XVI of the United States Social Security Act;

c) with respect to continuation upon the Employee's death, the Employee's legal divorce or legal separation or the end of an insured Dependent's eligibility, the end of the 36 month period which starts on the date the group health benefits would otherwise end;
d) with respect to a Dependent whose continuation is extended due to the Employee's entitlement to Medicare, the end of the 36 month period which starts on the date the group health benefits would otherwise end;
e) the date this Policy ends;
f) the end of the period for which the last premium payment is made;
g) the date he or she becomes covered under any other group health plan which contains no limitation or exclusion with respect to any Pre-Existing Condition of the Qualified Continuee or contains a pre-existing conditions limitation or exclusion that is eliminated through the Qualified Continuee's total period of Creditable Coverage.;
h) the date he or she becomes entitled to Medicare;
i) termination of a Qualified Continuee for cause (e.g. submission of a fraudulent claim) on the same basis that the Employer terminates coverage of an active employee for cause.

NEW JERSEY GROUP CONTINUATION RIGHTS (NJGCR)

Important Notice
Except as stated below, under this section, "Qualified Continuee" means any person who, on the day before any event which would qualify him or her for continuation under this section, is covered for group health benefits under this Policy as:
a) a full-time covered Employee;
b) the spouse of a full-time covered Employee; or
c) the Dependent child of a full-time covered Employee.
Exception: A Newly Acquired Dependent, where birth, adoption, or marriage occurs after the Qualifying Event is also a "Qualified Continuee" for purposes of being included under the Employee's continuation coverage.

If An Employee's Group Health Benefits Ends
If an Employee's group health benefits end due to his or her termination of employment or reduction of work hours to fewer than 25 hours per week, he or she may elect to continue such benefits for up to 18 months, unless he or she was terminated for cause. The Employee's spouse

and Dependent children may elect to continue benefits even if the Employee does not elect continuation for himself or herself.

A Qualified Continuee may elect to continue coverage under NJGCR even if the Qualified Continuee:
a) is covered under another group plan on or before the date of the NJGCR election; or
b) is entitled to Medicare on or before the date of the NJGCR election.

The continuation:
a) may cover the Employee and/or any other Qualified Continuee; and
b) is subject to the When Continuation Ends section.

Extra Continuation for Disabled Qualified Continuees
If a former Employee who is a Qualified Continuee is determined to be disabled under Title II or Title XVI of the United States Social Security Act on the date his or her group health benefits would otherwise end due to the termination of employment or reduction of work hours to fewer than 25 hours per week or during the first 60 days of continuation coverage, he or she may elect to extend his or her 18-month continuation period for himself or herself and any Dependents who are Qualified Continuees for up to an extra 11 months.

To elect the extra 11 months of continuation, the Qualified Continuee must give the Horizon BCBSNJ written proof of Social Security's determination of his or her disability before the earlier of:
a) the end of the 18 month continuation period; and
b) 60 days after the date the Qualified Continuee is determined to be disabled.

If, during this extra 11 month continuation period, the Qualified Continuee is determined to be no longer disabled under the Social Security Act, he or she must notify the Horizon BCBSNJ within 31 days of such determination, and continuation will end, as explained in the When Continuation Ends section.

An additional 50% of the total premium charge also may be required from the Qualified Continuee by the Employer during this extra 11 month continuation period.

If An Employee Dies While Insured
If an Employee dies while insured, any Qualified Continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to the When Continuation Ends section.

If An Employee's Marriage or Civil Unionor Domestic Partnership Ends
If an Employee's marriage ends due to legal divorce or legal separation or dissolution of the civil unionor termination of a domestic partnership, any Qualified Continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to the When Continuation Ends section.

If A Dependent Loses Eligibility
If a Dependent child's group health benefits end due to his or her loss of dependent eligibility as defined in this Policy, other than the Employee's coverage ending, he or she may elect to continue such benefits for up to 36 months, subject to When Continuation Ends.

The Employer's Responsibilities

Upon loss of coverage due to termination of employment or reduction in work hours, the Employer must notify the former employee in writing, of:

a) his or her right to continue this Policy's group health benefits;
b) the monthly premium he or she must pay to continue such benefits; and
c) the times and manner in which such monthly payments must be made.

Upon being advised of the death of the Employee, divorce, dissolution of the civil union termination of a domestic partnership or Dependent child's loss of eligibility, the Employer should notify the Qualified Continuee in writing, of:

a) his or her right to continue this Policy's group health benefits;
b) the monthly premium he or she must pay to continue such benefits; and
c) the times and manner in which such monthly payments must be made.

Election of Continuation

To continue his or her group health benefits, the Qualified Continuee must give the Employer written notice that he or she elects to continue. An election by a minor Dependent Child can be made by the Dependent Child's parent or legal guardian. This must be done within 30 days of the date coverage ends. The first month's premium must be paid within 30 days of the date the Qualified Continuee elects continued coverage.

The subsequent premiums must be paid to the Employer, by the Qualified Continuee, in advance, at the times and in the manner specified by the Employer.

The monthly premium will be the total rate which would have been charged for the group health benefits had the Qualified Continuee stayed insured under this Policy on a regular basis. It includes any amount that would have been paid by the Employer. Except as explained in the Extra Continuation for Disabled Qualified Continuees section, an additional charge of two percent of the total premium charge may also be required by the Employer.

If the Qualified Continuee does not give the Employer notice of his or her intent to continue coverage, or fails to pay any required premiums in a timely manner, he or she waives his or her continuation rights.

Grace in Payment of Premiums

A Qualified Continuee's premium payment is timely if, with respect to the first payment after the Qualified Continuee elects to continue, such payment is made no later than 30 days after such election. In all other cases, such premium payment is timely if it is made within 31 days of the date it is due.

The Continued Coverage

The continued coverage shall be identical to the coverage provided to similarly situated active Employees and their Dependents under the Employer's plan. If coverage is modified for any group of similarly situated active Employees and their Dependents, the coverage for Qualified Continuees shall also be modified in the same manner. Evidence of insurability is not required for the continued coverage.

When Continuation Ends

A Qualified Continuee's continued group health benefits end on the first of the following:

a) with respect to continuation upon the Employee's termination of employment or reduction of work hours, the end of the 18 month period which starts on the date the group health benefits would otherwise end;

b) with respect to a Qualified Continuee who has elected an additional 11 months of continuation due to his or her own disability, the end of the 29 month period which starts on the date the group health benefits would otherwise end. However, if the Qualified Continuee is no longer disabled, coverage ends on the later of:
   - the end of the 18-month period; or
   - the first day of the month that begins more than 31 days after the date on which a final determination is made that a disabled Qualified Continuee is no longer disabled under Title II or Title XVI of the United States Social Security Act;

c) with respect to continuation upon the Employee's death, the Employee's legal divorce or legal separation, dissolution of the civil union or termination of a domestic partnership or the end of an insured Dependent's eligibility, the end of the 36 month period which starts on the date the group health benefits would otherwise end;

d) the date the Employer ceases to provide any health benefits plan to any active Employee or Qualified Continuee;

e) the end of the period for which the last premium payment is made;

f) the date he or she first becomes covered under any other group health benefits plan, as an employee or otherwise, which contains no limitation or exclusion with respect to any Pre-Existing Condition of the Qualified Continuee; or

g) the date he or she first becomes entitled to Medicare.

NEW JERSEY CONTINUATION RIGHTS FOR OVER-AGE DEPENDENTS (Applies to all size groups):

As used in this provision, “Over-Age Dependent” means an Employee’s child by blood or law who:

a) has reached the limiting age under the group plan, but is less than 31 years of age;

b) is not married or in a domestic partner or civil union partnership;

c) has no Dependents of his or her own;

d) is either a resident of New Jersey or is enrolled as a full-time student at an Accredited School; and

e) is not covered under any other group or individual health benefits plan, group health plan, church plan or health benefits plan, and is not entitled to Medicare on the date the Over-Age Dependent continuation coverage begins.

If A Dependent Is Over the Limiting Age for Dependent Coverage

If a Dependent Child is over the age 26 limiting age for dependent coverage and:

a) the Dependent child's group health benefits are ending or have ended due to his or her attainment of age26; or

b) the Dependent child has proof of prior creditable coverage or receipt of benefits,
he or she may elect to be covered under the Employer’s plan until his or her 31st birthday, subject to the Conditions for Election, Election of Continuation and When Continuation Ends sections below.

Conditions for Election

An Over-Age Dependent is only entitled to make an election for continued coverage if all of the following conditions are met.

a) The Over-Age Dependent must provide evidence of prior creditable coverage or receipt of benefits under a group or individual health benefits plan, group health plan, church plan or health benefits plan or Medicare. Such prior coverage must have been in effect at some time prior to making an election for this Over-Age Dependent coverage.
b) A parent of an Over-Age Dependent must be enrolled as having elected Dependent coverage at the time the Over-Age Dependent elects continued coverage. Except, if the Employee has no other Dependents, or has a Spouse who is covered elsewhere, the Over-Age Dependent may nevertheless select continued coverage.

Election of Continuation
To continue group health benefits, the Over-Age Dependent must make written election to Horizon BCBSNJ. The effective date of the continued coverage will be the later of:
a) the date the Over-Age Dependent gives written notice to Horizon BCBSNJ or
b) the date the Over-Age Dependent pays the first premium; or
c) the date the Dependent would otherwise lose coverage due to attainment of age 26.

For a Dependent whose coverage has not yet terminated due to the attainment of the limiting age, the written election must be made within 30 days prior to termination of coverage due to the attainment of the limiting age if the Dependent child seeks to maintain continuous coverage. The written election may be made later, and if made later would result in a lapse in coverage. See the Application of a Pre-existing Conditions Exclusion section below.

For a Dependent who was not covered on the date he or she reached the limiting age, the written election may be made at any time. See the Application of a Pre-existing Conditions Exclusion section below.

For a person who did not qualify as an Over-Age Dependent because he or she failed to meet all the requirements of an Over-Age Dependent, but who subsequently meets all of the requirements for an Over-Age Dependent, written election may be made at any time after the person meets all of the requirements for an Over-Age Dependent. See the Application of a Pre-existing Conditions Exclusion section below.

Application of a Pre-Existing Conditions Exclusion
An Over-Age Dependent who was covered under prior Creditable Coverage that terminated no more than 90 days prior to making an election for continuation under this section will be given credit for the time he or she was covered under the Creditable Coverage toward the application of the Pre-Existing Conditions Exclusion under the Policy.

Payment of Premium
The first month's premium must be paid within 30 days of the date the Over-Age Dependent elects continued coverage.

The Over-Age Dependent must pay subsequent premiums monthly, in advance, at the times and in the manner specified by Horizon BCBSNJ. The monthly premium will be set by the Carrier, and must be consistent with the requirements of P.L. 2005, c. 375.

Grace in Payment of Premiums
An Over-Age Dependent's premium payment is timely if, with respect to the first payment after the Over-Age Dependent elects to continue, such payment is made no later than 30 days after such election. In all other cases, such premium payment is timely if it is made within 30 days of the date it is due.

The Continued Coverage
The continued coverage shall be identical to the coverage provided to the Over-Age Dependent's parent who is covered as an Employee under the Policy and will be evidenced by a separate Certificate and ID card being issued to the Over-Age Dependent. If coverage is modified for Dependents who are under the limiting age, the coverage for Over-Age Dependents shall also be modified in the same manner. Evidence of insurability is not required for the continued coverage.

When Continuation Ends
An Over-Age Dependent's continued group health benefits end on the first of the following:

a) the date the Over-Age Dependent:
    1. attains age 31
    2. marries or enters into a civil union partnership;
    3. acquires a Dependent;
    4. is no longer either a resident of New Jersey or enrolled as a full-time student at an Accredited School; or
    5. becomes covered under any other group or individual health benefits plan, group health plan, church plan or health benefits plan, or becomes entitled to Medicare.
b) the end of the period for which premium has been paid for the Over-Age Dependent, subject to the Grace Period for such payment;
c) the date the Policy ceases to provide coverage to the Over-Age Dependent's parent who is the Employee under the Policy.
d) The date the Policy under which the Over-Age Dependent elected to continue coverage is amended to delete coverage for Dependents.
e) The date the Over-Age Dependent's parent who is covered as an Employee under the Policy waives Dependent coverage. Except, if the Employee has no other Dependents, the Over-Age Dependent's coverage will not end as a result of the Employee waiving Dependent coverage.

A TOTALLY DISABLED EMPLOYEE'S RIGHT TO CONTINUE GROUP HEALTH BENEFITS

If An Employee is Totally Disabled
An Employee who is Totally Disabled and whose group health benefits end because his or her active employment or membership in an eligible class ends due to that disability, can elect to continue his or her group health benefits. But he or she must have been insured by this Policy for at least three months immediately prior to the date his or her group health benefits ends. The continuation can cover the Employee, and at his or her option, his or her then insured Dependents.

How And When To Continue Coverage
To continue group health benefits, the Employee must give the Employer written notice that he or she elects to continue such benefits. And he or she must pay the first month's premium. This must be done within 31 days of the date his or her coverage under this Policy would otherwise end.

Subsequent premiums must be paid to the Employer monthly, in advance, at the times and in the manner specified by the Employer. The monthly premium the Employee must pay will be the total rate charged for an active Full-Time Employee, insured under this Policy on a regular basis, on the date each payment is due. It includes any amount which would have been paid by the Employer.

Horizon BCBSNJ will consider the Employee's failure to give notice or to pay any required premium as a waiver of the Employee's continuation rights.